1. Financing existing on September 1, 1999 must be through the Maine Health and Higher Educational Facilities Authority; and

2. Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department; and

3. In the Department's judgement, failure to approve may adversely affect resident care; and

4. In the Department's judgement, approval will further the Department's goal of ensuring that public funds are only expended for services that are necessary for the well being of the citizens of Maine.

44.4.4 Sale and Leaseback Agreements-Rental Charges. Rental costs specified in sale and leaseback agreements incurred by providers through selling physical plant facilities or equipment to a purchaser not connected with or related to the provider, and concurrently leasing back the same facilities or equipment, are includable in allowable cost.

However, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs, had he retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance and maintenance costs.

44.5 Interest Expense

44.5.1 Principle. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

44.5.2 Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the costs incurred for funds borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Except as provided in subsection 44.5.4.6, interest does not include interest and penalties charged for failure to pay accounts when due.

44.5.3 Necessary. In order to be considered "necessary", interest must:

44.5.3.1 Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would be considered unnecessary; and

44.5.3.2 Be reduced by investment income except where such income is from gifts, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation is not used to reduce interest expense.

44.5.3.3 Proper. Proper requires that interest:

44.5.3.3.1 Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

44.5.3.3.2 Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.

44.5.3.4 Refinancing. Any refinancing of property mortgages or loans on fixed assets must be prior approved by the Department. If prior approval is not obtained any additional interest costs or finance charges will not be allowed.

44.5.4 Borrower-lender relationship

44.5.4.1 To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement with higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm's-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowed. However, interest on first or second mortgages held by stockholders, owners, relatives or related organizations of the provider, will be treated as an allowable cost if it is in line with the interest rates charged by lending institutions at the inception of the loan. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital.

44.5.4.2 Exceptions to the general rule regarding interest on loans from controlled sources of funds. Where the general fund of a provider borrows from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money borrowed from the funded depreciation account of the provider. In addition, if a provider of a facility operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost. Interest paid by the provider cannot exceed interest earned by the above subject funds.

44.5.4.3 Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to resident care, or payment of long-term debt principle once the principle payment exceeds the straight-line depreciation allowed under the Principles of Reimbursement, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation.

44.5.4.4 Loans not reasonably related to resident care. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost are not considered to be for a purpose reasonably related to resident care.

44.5.4.5 Interest expense of related organizations. Where a provider leases facilities from a related organization and the rental expense paid to related organization is not allowable as a cost, costs of ownership of the leased facility are allowable as in interest cost to the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider.

44.5.4.6 Interest on Property Taxes. Interest charged by a municipality for late payment of property taxes is an allowable cost when the following conditions have been met:

44.5.4.6.1 The rate of interest charged by the municipality is less than the interest which a prudent borrower would have had to pay in the money market existing at the time the loan was made;

44.5.4.6.2 The payment of property taxes is deferred under an arrangement acceptable to the municipality;

44.5.4.6.3 The late payment of property taxes results from the financial needs of the provider and does not result in excess funds; and

44.5.4.6.4 Approval in writing has been given by the Department prior to the time period in which the interest is incurred. Any requests for prior approval must be received by the Department at least two weeks prior to the desired effective date of the approval.

44.5.4.7 Limitation on the participation of capital expenditures. Interest is not allowable with respect to any capital expenditure in plant and property, and equipment related to resident care, which did not receive a required Certificate of Need Review approval.

44.5.5 The Department will make adjustments to the nursing facility's fixed cost component of the per diem rate to reflect the effect of refinancing which results in lower interest payments.

44.6 Return on Equity Capital of Proprietary Providers

44.6.1 Principle. A reasonable return on equity capital invested and used in the provision of resident care is allowable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The amount on an annual basis is eight percent (8%).

44.6.2 For purposes of this subpart, the term "propriety providers" means providers, whether sole proprietorships, partnerships or corporations organized and operated with the expectation of earning profits for the owners, as distinguished from providers organized and operated on a non-profit basis.

44.6.3 For the purpose of computing the allowable return, the provider's equity capital means:

44.6.3.1 The provider's investment in plant and property and equipment related to resident care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to resident care and is required by the terms of the lease to deposit such funds (net or noncurrent debt related to such investment or deposited funds) and,

44.6.3.2 Net working capital maintained for necessary and proper operation of resident care activities.

44.6.3.3 Notwithstanding anything in Subsection 44.6.3.1 and 44.6.3.2 debt representing loans from partners, stockholders, or related organizations, on which interest payments would be allowable as costs but for Subsection 44.5.4.1 is included in computing the amount of equity capital in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost.

44.6.4 Acquisitions. For facilities or tangible assets acquired, the excess of the purchase price paid for a facility or assets over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible asset, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital.

44.6.5 Computation of return on equity capital. For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

44.6.6 Unapproved capital expenditures. With respect to any capital expenditure, a provider's investment in plant, property and equipment related to resident care, and funds deposited by a provider which leases plant, property, or equipment related to resident care which are found to be expenditures which have not been submitted to the designated planning agency as required, or have been determined to be inconsistent with health facility planning requirements, are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

44.6.7 Exclusion from Computation of Average Equity Capital. For the purpose of computing average equity capital, the following are examples of items not to be included in the computation:

44.6.7.1 Notes and loans receivable from owners or related organizations.
44.6.7.2 Goodwill.
44.6.7.3 Unpaid capital surplus.
44.6.7.4 Treasury Stock.
44.6.7.5 Unrealized capital appreciation surplus.
44.6.7.6 Cash surrender value of life insurance policies.
44.6.7.7 Prepaid premiums on life insurance policies.
44.6.7.8 Assets acquired in anticipation of expansion and not presently used in the provider's operation or in the maintenance of resident care activities during the rate period.

44.6.7.9 Inter-company accounts.
44.6.7.10 The portion of the value of any motor vehicle that is attributed to personal use.
44.6.7.11 Any other assets not directly related to or necessary for the provision of resident care to publicly aided residents.
44.6.7.12 Funded Depreciation.
44.6.7.13 Accrued interest on related party loans and cash invested in money market accounts or savings accounts for a period of over six months.

44.7 Insurance. Reasonable and necessary costs of insurance involved in operating a facility are considered allowable costs (real estate insurance including liability and fire insurance are included as fixed costs - see subsection 44.1.4). Premiums paid on property not used for resident care are not allowed. Life insurance's premiums related to insurance on the lives of key employees where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured officer or key employee the insurance proceeds are payable directly to the provider. An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer the proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because it does not receive the proceeds directly, but is, nevertheless, an indirect beneficiary since its liability on the loan is reduced.

44.71 Worker's Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine for facility fiscal years that began on or after October 1, 1992, and deductibles paid by facilities related to such cost are allowable fixed costs. Estimated amounts for workers compensation insurance audit premiums will not be accepted as an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of worker's compensation insurance. In those instances where the Department finds that a facility pays more than the usual and customary rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under Medicaid. Allowable costs are subject to an experience modifier of 1.4; that is, cost associated with an experience modifier of 1.4 or under are allowable. Workers compensation costs incurred above the experience modifier of 1.4 shall be considered unallowable and will be settled at time of audit.

44.71.1 The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $40.00 per covered employee per year for nursing facilities with an experience modifier greater than .9. The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $70.00 per covered employee per year for nursing facilities with an experience modifier equal to or less than .9. Allowable costs shall include the cost of educational programs and training classes, transportation to and from those classes, lodging when necessary to attend the classes, materials needed in the preparation and presentation of the classes (when held at the nursing facility), and equipment (e.g.: lifts) which lead towards accomplishing the established goals and objectives of the facility's safety program. Non-allowable costs include salaries paid to individuals attending the safety classes and personal gifts such as bonuses, free passes to events or meals, and gift baskets.

44.71.2 The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 Administrator in Training. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of Human Services recovering 100% of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, 100% of the amount allowed will be recovered by the Department.

44.9 Acquisition Costs. Fifty percent of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion (at least 50%) of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition. This acquisition cost will not include any fees (eg: accounting, legal) associated with the acquisition.

44.10 Occupancy Adjustment.

Facilities With Greater Than 60 Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). Effective January 1, 2003, to the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than eighty-five percent (85%). For all new providers coming into the program, the 85% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit.

Facilities With 60 or Fewer Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). Effective January 1, 2003, to the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than eighty percent (80%). For all new providers of sixty (60) or fewer beds coming into the program, the 80% occupancy adjustment will not apply for the first 90 days of operation. It

will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit.

44.11 Start Up Costs Applicability

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first resident is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing resident care functions or unallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first resident is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first resident is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for resident care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a resident care area, depreciation should start with the month the first resident is admitted for treatment. If the portion of the facility is a nonrevenue - producing resident care area or unallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of 60 consecutive months beginning with the month in which the first resident is admitted for treatment.

Where a provider prorates portions of its facility for resident care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for resident care services during different periods of time.

44.12 Return on Net Assets for Non-Profit Providers – A reasonable return on net assets invested and used in the provision of resident care is allowable as an element of the reasonable cost of covered services furnished to

the beneficiaries by nonprofit providers. The amount on an annual basis is equal to one quarter (1/4) of the amount allowed for proprietary providers as stated in Section 44.6.1 of these Principles of Reimbursement.

44.12.1 The calculation of the return on net assets will be made in accordance with Sections 44.6.3 – 44.6.7.13 of these Principles of Reimbursement.

50 PUBLIC HEARING

The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

70 SPECIAL SERVICE ALLOWANCE

70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility.

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific resident. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)

OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

80.1 Principle. For services provided on or after July 1, 2000, the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year ending in 1998, as determined from the audited cost report (or as filed cost report) will be the basis for the base year computations (subject to upper limits). Allowable costs are separated into three components - direct, routine and fixed costs.

The base year direct and routine cost component costs will be trended forward using the inflationary factors from the table "HCFA Nursing Home Without Capital Market Basket" from the publication Health Care Costs

published by DRI/McGraw-Hill as described in Section 91. (See Section 80.3 for a complete description of the rate setting process for the direct care component and inflation guidelines from the base year through 6/30/00.) Inflation factor data for salaries will be acquired from the Maine Health Care Facility Economic Trend Factor. The inflation factors will be based on the most recent DRI publications available at the times the rates are determined. Beginning October 1, 1993 the determination of the direct care cost component of each facility's base year rate will be computed by calculating the facility's case mix adjusted cost per day pursuant to Section 80.3. The prospective rate shall consist of three components : the direct care cost component as defined in Section 41, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

80.2 FIXED COST COMPONENT

The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating periods. To the extent that fixed costs are allowable, such cost will be adjusted for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

80.3 DIRECT CARE COST COMPONENT

80.3.1 Case Mix Reimbursement System

80.3.1.1 The direct care cost component utilizes a case mix reimbursement system. Case mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(a) the assessment of residents on the Department's approved form - MDS as specified in Section 41.2.;

(b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Section 80.3.2.;

(c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index.

80.3.2 Case mix resident classification groups and weights

There are a total of 45 case mix resident classification groups, including one resident classification group used when residents can not be classified into one of the 44 clinical classification groups.

Each case mix classification group has a specific case mix weight as follows:

RESIDENT CLASSIFICATION GROUP		CASE MIX WEIGHT
REHABILITATION		
REHAB ULTRA HI/ADL	16-18	1.986
REHAB ULTRA HI/ADL	9-15	1.426
REHAB ULTRA HI/ADL	4 - 8	1.165
REHAB VERY HI/ADL	16-18	1.756
REHAB VERY HI/ADL	9-15	1.562
REHAB VERY HI/ADL	4 - 8	1.217
REHAB HI/ADL	13-18	1.897
REHAB HI/ADL	8-12	1.559
REHAB HI/ADL	4 - 7	1.260
REHAB MED/ADL	15-18	2.051
REHAB MED/ADL	8 -15	1.635
REHAB MED/ADL	4 - 7	1.411
REHAB LOW/ADL	4 -18	1.829
REHAB LOW/ADL	4-11	1.256
EXTENSIVE		
EXTENSIVE 3/ADL	7-18/Head Injury – ADL 15 - 18	2.484
EXTENSIVE 2/ADL	7-18/Head Injury – ADL 10 - 14	2.057
EXTENSIVE 1/ADL	7-18/Head Injury – ADL 7 - 9	1.910
SPECIAL CARE		
SPECIAL CARE/ADL	17-18	1.841
SPECIAL CARE/ADL	15-16	1.709
SPECIAL CARE/ADL	7-14	1.511
CLINICALLY COMPLEX		
CLIN. COMP W/DEP/ADL	17-18	1.826
CLIN. COMP/ADL	17-18	1.663
CLIN. COMP W/DEP/ADL	12-16	1.503
CLIN. COMP/ADL	12-16	1.389

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CLIN. COMP W/DEP/ADL	4-11	1.331
CLIN. COMP/ADL	4-11	1.149
IMPAIRED COGNITION		
COG. IMPAIR W/RN REHAB/ADL	6-10	1.199
COG. IMPAIR/ADL	6-10	1.152
COG. IMPAIR W/RN REHAB/ADL	4-5	0.945
COG. IMPAIR/ADL	4-5	0.888
BEHAVIOR PROBLEMS		
BEHAVE PROB W/RN REHAB/ADL	6-10	1.180
BEHAVE PROB/ADL	6-10	1.123
BEHAVE PROB W/RN REHAB/ADL	4-5	0.905
BEHAVE PROB/ADL	4-5	0.759
PHYSICAL FUNCTIONS		
PHYSICAL W/RN REHAB/ADL	16-18	1.454
PHYSICAL/ADL	16-18	1.421
PHYSICAL W/RN REHAB/ADL	11-15	1.323
PHYSICAL/ADL	11-15	1.281
PHYSICAL W/RN REHAB/ADL	9-10	1.219
PHYSICAL/ADL	9-10	1.088
PHYSICAL W/RN REHAB/ADL	6-8	0.833
PHYSICAL/ADL	6-8	0.854
PHYSICAL W/RN REHAB/ADL	4-5	0.776
PHYSICAL ADL	4-5	0.749
UNCLASSIFIED		0.749

80.3.3 Base Year Direct Care Cost Component

80.3.3.1 Source of base year cost data. The source for the direct care cost component of the base year cost data is the audited cost report (as filed cost report if an audit has not been completed) for the nursing facility's fiscal year ending in calendar year 1998, except for facilities whose Medicaid rates are determined in accordance with Sections 80.6 and 80.7. The total audited allowable direct care costs are divided by the total actual audited days. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

80.3.3.2 Case Mix Index

The Bureau of Medical Services shall compute each facility's case mix index for the base year as follows:

(a) For non-hospital based facilities, the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of September 15, 1998 and received in the MDS CORE system by September 15, 2000. For hospital based facilities, the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of September 15, 1998 and received in the MDS CORE system by September 19, 2000. For new facilities, see 80.6.5.

(b) For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group excluding the residents in the unclassified group by the case mix weight for the relevant classification group.

(c) The sum of these products divided by the total number of Medicaid residents excluding the residents in the unclassified group equals the facility's base year case mix index.

80.3.3.3 Base year case mix adjusted Medicaid cost per day.

Each facility's direct care case mix adjusted cost per day will be calculated as follows:

(a) The facility's direct care cost per day, as specified in Section 80.3.3.1, is divided by the facility's base year case mix index to yield the case mix adjusted cost per day.

80.3.3.4 Array of the base year case mix adjusted cost per day.

The direct care cost component will be inflated from the end of the facility's base year through June 30, 2000 using regional variations in labor costs calculated by using the average percentage increase in the weighted average actual salaries paid by nursing facilities to direct care staff as stated on the 1998 costs reports to the weighted average actual salaries paid to direct care staff as stated on the 1999 cost reports.

For each peer group (hospital based facilities, non-hospital based facilities with less than or equal to sixty beds, and non-hospital based facilities with greater than 60 beds), the Bureau shall array all nursing facilities case mix adjusted costs per day inflated to June 30, 2000 from high to low and identify the median.

80.3.3.5 Limits on the base year case mix adjusted cost per day.

For hospital based facilities, the upper limit on the base year case mix adjusted cost per day shall be the median plus fifty per cent (50%); for non-hospital based facilities with less than or equal to 60 beds, the upper limit on the base year case mix adjusted cost per day shall be the median plus ten per cent (10%); and for non-hospital based facilities with greater than 60 beds, the upper limit on the base year case mix adjusted cost per day shall be the median plus ten percent (10%).

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80.3.3.6 Each facility's case mix direct care rate shall be the lesser of the limit in Section 80.3.3.5. or the facility's base year case mix adjusted cost per day.

80.3.4 Quarterly Calculation of the Direct Care Component

The Bureau of Medical Services shall compute the direct resident care cost component for each facility on a quarterly basis.

80.3.4.1 Calculation of the quarterly case mix index.

The Bureau of Medical Services shall compute each facility's quarterly case mix index for the rate period as follows:

For each facility the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS on all Medicaid residents in the facility as of the 15th day of the prior quarter (e.g. For a October 1 rate, the facility's case mix index would be computed using the most recent assessments of Medicaid residents with an assessment date of June 15.)

For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group including those in the unclassified group by the case mix weight for the relevant classification group. The sum of these products divided by the total number of Medicaid residents equals the facility's quarterly case mix index. The roster sent to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing facilities responsibility to check the roster and make corrections within one week of receiving the roster and submit such corrections to the Department or it's designee. MDS Corrections for assessments used in the calculation of a facility's quarterly case mix index will not be considered in the calculation of the index when received in the MDS CORE system after the calculation of the rate by the Bureau of Medical Services.

For purposes of this section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For Medicaid residents, the facility would be paid the facility rate for the number of days the resident is at the facility.)

80.3.4.2 Direct Care rate per day

The direct care rate per day shall be computed by multiplying the allowable base year case mix adjusted cost per day by the applicable case mix index.

80.3.4.3 The direct cost, as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct care costs (subject to the limitations cited in Section 41) from the base year by the inflationary factor defined in Section 91, for dates of service on or after July 1, 2000.

80.3.4.4 Public Law 99, Chapter 731, appropriated funds to assist nursing facilities to maintain minimum staffing ratios. The Department used base year cost report information (in aggregate) in determining whether a facility was at or below the minimum staffing requirements. The Department excluded two full-time equivalent direct care positions for every 50 licensed beds from the direct care hours to allow for staff time that may not involve hands-on direct care when calculating whether a facility was meeting the minimum staffing requirements. For purposes of determining the total base year allowable direct care cost, nursing facilities not meeting the minimum staffing ratios will have their base year allowable direct care cost component increased by the weighted average hourly rate of their base year direct care staff costs plus the statewide average fringe benefits percentage times the number of hours needed to meet those minimum staffing ratios.

The minimum staffing ratios are:

(a) 1 direct care staff person on the day shift to every 5 residents.
(b) 1 direct care staff person on the evening shift to every 10 residents.
(c) 1 direct care staff person on the night shift for every 15 residents.

80.3.4.4.1 The law defines direct care staff, for the purposes of meeting these minimum requirements as registered nurses, licensed practical nurses, and certified nursing assistants who provide direct care to nursing facility residents.

80.3.4.4.2 Direct Care is defined as hands-on care provided to residents, including, but not limited to, feeding, bathing, toileting, dressing, lifting, and moving residents. Direct care does not include food preparation, housekeeping, or laundry services except in circumstances when such services are required to meet the needs of an individual resident on a given occasion.

80.3.5 Direct Care Cost Settlement.

For dates of service beginning on or after July 1, 2000 facilities that incur allowable direct care costs during their fiscal year which are less than their prospective rate for direct care will receive their actual cost.

Facilities, which incur allowable direct care costs during their fiscal year in excess of their prospective rate for direct care, will receive no more than the amount allowed by the prospective rate.

80.5 ROUTINE COST COMPONENT

Routine Cost component base year rates shall be computed as follows:

80.5.1 Using each facility's base year fiscal year ending in calendar year 1998) audited cost report, the provider's base year total allowable routine costs shall be determined in accordance with Section 43.

80.5.2 The base year per diem allowable routine care costs for each facility shall be calculated by dividing the base year total allowable routine care costs by the greater of actual or 85% of the total Base Year resident days for hospital based facilities and non-hospital based facilities with less than or equal to 60

beds. The base year per diem allowable routine care costs for non-hospital based facilities with greater than 60 beds shall be calculated by dividing the base year total allowable routine care costs by the greater of actual or 90% of the total Base Year resident days.

80.5.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable routine costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.5.4 For hospital based facilities, the upper limit on the base year cost per day shall be the median plus fifteen per cent (15%); for non-hospital based facilities with less than or equal to 60 beds, the upper limit on the base year case mix adjusted cost per day shall be the median plus ten per cent (10%); and for non-hospital based facilities with greater than 60 beds, the upper limit on the base year cost per day shall be the median plus seven percent (7%). The per diem upper limits shall be services beginning on or after July 1, 2000.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.5.4 or the facility's base year per diem allowable routine care costs.

80.5.6 Routine Cost Settlement. Facilities that incur allowable routine costs less than their prospective rate for routine costs may retain any savings as long as it is used to cover direct care costs. Facilities that incur allowable routine costs during their fiscal year in excess of the routine cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.6 RATES FOR FACILITIES RECENTLY SOLD, RENOVATED OR NEW FACILITIES

80.6.1 A nursing home project that proposes renovation, replacement or other actions that will increase Medicaid costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of the rate supported by the costs submitted by the applicant or the statewide base year median for the direct and routine cost components inflated to the current period. The fixed costs determined through the Certificate of Need review process must be approved by the Bureau of Medical Services (also see Section 44.25.2).

80.6.1.1 For a facility sold after October 1, 1993, the direct and routine rate shall be the lessor of the rate of the seller or the rate supported by the costs submitted by the purchaser of the facility. The fixed cost component recognized by the Medicaid program will be determined through the Certificate of Need review process. Fixed costs determined through the certificate of need review process must be approved by the Bureau of Medical Services.

80.6.2 Nursing facility's not required to file a certificate of need application, currently participating in the Medicaid program, that undergo replacement and/or renovation will have their appropriate cost components adjusted to reflect any change in allocated costs. However, the rates established for the affected cost components will not exceed the state median rates for facility's in its peer group. In those instances that the data supplied by the nursing facility to the Department indicates that any one component rate

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